Sentinel Event Newsletter

Division of Licensing and Certification
Maine Department of Health and Human Services

Issue 25, September 2020

Coronavirus Update

On April 24, Governor Mills signed an Executive Order extending the 45-day reporting requirement to 120 days for filing an RCA following a Sentinel Event set forth in 22 M.R.S. **This Order remains in effect.**

Find the latest information about Maine's response to COVID—19 and resources for Maine people on the Maine CDC website:

https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/airborne/coronavirus.shtml

Inside this issue

Communication and the Impact on Patient Safety

Many sentinel events and adverse patient outcomes are attributed to poor communication both within a facility and as part of a sequence of communications from provider to provider. Improved patient outcomes, decreased cost, and increased efficiency are enhanced by effective communication.

Think of a relay race at the local track and field event. Teams work together to race against other teams of the same number. The rules require each runner to carry a baton a specified distance and then hand-off the baton to the next runner. That runner then receives the baton and runs to the next runner; and so on until each runner has carried the baton and it is safely delivered across the finish line. What seems fairly straightforward is actually very intricate and complicated. Most teams assign the runners second fastest first, then third fastest followed by fourth fastest. The fastest runner is the last runner to run. Hopefully, the fourth runner can make up any time needed to win the race and deliver the baton to the finish line. How does this relate to health care delivery?

The relay race requires a series of communications between a number of people. Who will start the race and what is the best way to hand the baton to the next person on the team? How will that runner receive the baton without dropping it or tripping? This is how the relay race is similar to the delivery of health care and why communication is vital to good outcomes. Patients access the health care system in a variety of ways: They visit their PCP, a specialist, the Emergency Department, out-patient services, etc. Every time they access care or service information is "relayed" to a member of the team including the patient, family, or other providers.

According to The Joint Commission's (TJC) Sentinel Event Database, communication is a leading cause of sentinel events in the United States. Research conducted between 1995-2005 revealed that ineffective communication was the cause for approximately 66% of medical errors during that period. According to a report published in *FierceHealthcare*, "...poor communication has been a factor in 1,744 patient deaths and over $1.7 billion in malpractice costs nationally in the past five years. Improved communication would benefit patients and providers of all kinds."

According to Regis College, health care institutions use two types of communication: Interhospital and intrahospital. Interhospital communications involve information shared between multiple facilities or providers. This may include providers owned by the same corporate parent or providers within the same treatment area. Transferring patients, medical records, or equipment are some of the interhospital communications involved. A study conducted by the Center for Health Information and Decision Systems found that, "poor interhospital communication costs the industry upward of $12 billion annually."

Communication problems may also occur within the same hospital. This is Intrahospital communication. This type of communication may include scheduling surgeries, appointments within the facility, or times to obtain lab work. Inefficiencies in communication between staff, nurses, physicians, and others may cost thousands in unnecessary costs. Sentinel events and other serious medical errors are all effected by poor communication.

Evaluating the Efficacy of Root Cause Analyses

10-144 C.M.R Ch 114 Rules Governing the Reporting of Sentinel Events, Section 4. Root Cause Analysis (RCA), 4.2, RCA Required. The health care facility is "required to submit to the SET a thorough and credible root cause analysis no later than 45 days after notification of the sentinel event. The RCA may exclude protected professional competence review information pursuant to the Maine Health Security Act. See 22 M.R.S.A. §8753 (2)."

Section 4.3.4.5.2 requires "Identification of actions and rationale that clearly and specifically address each proximal cause and contributing factor of the sentinel event."

The goal of the root cause analysis (RCA) process is to identify opportunities for improvements in care and service that will result in better patient safety and outcomes. The *International Journal for Quality in Health Care,* Volume 30, Issue 2, March 2018, describes a study conducted between 2010 and 2015 in which the sustainability of RCA reports was evaluated. During the study, 227 RCA's were reviewed.

The big questions are: Does RCA work? Are actions sustainable? Do patients and staff benefit? Often, RCA recommendations are designated as "strong," "medium," and "weak". According to the authors of the study, "strong recommendations are those that, once implemented, rely less on people's actions, and memories, and are more likely to be effective and sustainable."

Weak recommendations rely on training and policy changes. They are less likely to provide sustainable improvement due to the fact that they rely on human behavior. In the study, interventions determined to be strong versus weak were evaluated. The study findings go on to share that half of the RCA-generated recommendations were determined to be weak and only one in 12 were determined to be strong.

Adverse and sentinel events are often attributed to human error, not following a policy or procedure, rather than digging deeper into what the underlying problems are within an organization.

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Potential problems when developing RCA recommendations:

- Analyses may end when the most convenient root cause is found, or one that fits the investigator's biases.
- The accuracy of the cause is dependent on the quality of the information gathered, which is often flawed.
- RCA teams are not obliged to use evidence to justify their recommendations.
- Recommendations are not clearly linked to one or more causative factors.
- Systematic methods for generating risk control recommendations are not widely used.
- Reports are often circulated to the participants for repeated comment and feedback, with the aim of "getting everybody on board" and maintaining consensus, resulting in few containing highly consequential findings or recommendations.
- Producing a "nice" report at times becomes the main goal of the investigation and displaces the original objective of the influencing learning and promoting change.
- The RCA process supports changes that hospital departments had previously promoted without success.
- Instead of a process of evidence-based change, RCA often results in "change-based evidence" whereby evidence about root causes is used to support existing agendas.

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The 5 Why's

"The basis of Toyota's scientific approach is to ask why five times whenever we find a problem … By repeating why five times, the nature of the problem as well as its solution becomes clear."

—*Taiichi Ohno*

COVID-19 and Patient Safety

It is not a surprise to anyone that 2020 has been quite a year for the health care industry. Early on, we started hearing that COVID-19 was making people sick in China, then it spread to other countries like South Korea, Italy, and by March we were in the midst of global pandemic with cases rising steadily in the United States. According to the US Centers for Disease Control and Prevention, total cases of COVID-19 exceeded 6 million by early September, including more than 183,000 deaths. The illness has taxed the health care industry to an extreme. Shortages of space, supplies, medication, and staffing continue to be problematic. Responding to COVID-19 has created an unknown number of missed or delayed diagnoses for non-COVID conditions. Patients are avoiding emergency room visits due to fear, loss of insurance, lack of income and resources, and rumors of long wait times.

Despite the best efforts of many, COVID-19 has impacted patient safety and the quality of care. It has increased risk for both patients and the staff who care for them. According to the Patient Safety Primer, "weaknesses are exacerbated by fatigue and burnout, absence of team trust, lack of time, medical illness, and poor psychological safety, each of which can result in reduced performance and contribute to failures such as misdiagnoses and adverse events."

Even in the best of times, fatigue and burnout are common in many health care settings. From routine bedside care, room turnover rates, availability of emergent services, and infection prevention, to the availability of personal protective equipment (PPE), the delivery of health care can be stressful for staff at all levels.

- A study of health care providers and staff in the Hunan province of China found that explicit evidence-based infection control guidelines, customized equipment, and specialized units for COVID-19 patients helped to decrease burnout.
- The Italian COVID-19 experience found that providing opportunities for peer support to health care staff helped remove the stigma of seeking help for stress related concerns.

One doesn't often think about trust among care team members as having an impact on patient safety, however, according to an article entitled "COVID-19 Team and Human Factors to Improve Safety," featured in PSNet, the absence of trust among caregivers does have a direct impact on patient safety. In some areas, patients seeking care for COVID-19 have flooded local health care delivery systems, requiring an influx of clinicians being pulled together to work in teams. This rapid team formation stresses the development of trust among care team members. In response to COVID-19, teams are pulling together with limited, or no, knowledge of one another. Team members may have limited, or brand new, skill sets. This adds stress to an already stressful situation. Stress and anxiety can impact patient safety and contribute to adverse events. There are processes to support team development already in place in most health care settings.

- Huddles: Huddles support communication and the sharing of information amongst team members. Team members who are new to the situation are informed. This helps with role clarification and clinical task assignments. Effective communication is vital to patient safety.
- Debriefings: Debriefings allow team members to review performance, share care insights, and identify areas for improvement in care and safety. Long utilized in the area of emergency preparedness, debriefings provide an opportunity to learn from experiences.
- Checklists: New team members should utilize existing processes while orienting to new environments. They should be encouraged to speak up when they identify areas in patient safety that could be improved.

Care delivery teams have experienced pressure to meet the demands of the COVID-19 pandemic. Anxiety related to this situation can lead to errors, miss communication, and an increase in adverse events. Interventions to decrease the chance of errors are sometimes simple. For example, signage can be utilized to remind staff, both new and experienced, to wash hands, find equipment like PPE, and to maintain space requirements and social distancing. Checklists can be helpful to ensure that steps in care are not overlooked. These kinds of interventions are easy to implement and can impact patient care and therefore, patient safety.

COVID Response Leads to Improvement in Care

Adapting to the difficulties of providing care during the COVID-19 pandemic has been a challenge for health care systems. Major, system-wide changes have been implemented in a matter of days and weeks, rather than months or even years. But the silver lining is that many of these changes have been positive for patient care overall:

Shifts in the use of telemedicine: According to *MedPage Today*, health care visits delivered remotely at Kaiser Permanente have increased from about one in five before the pandemic to more than four in five today.

At home screening tests: Home tests provide tools for surveillance while decreasing the number of in person appointments and procedures needed to monitor many conditions.

Virtual exams: Virtual exams are providing better access to care for many. Today, virtual hearing exams allow individuals to be assessed with home electronic devices.

Medication management: Many patients require blood tests to monitor drug efficacy and avoid adverse events. Some newer medications are being managed without frequent lab tests.

Shifting resources: With the need of in-person visits decreasing due to COVID-19, staff are being reassigned to follow up with patients to discuss treatment plans or schedule preventive screening. These follow-up efforts sometimes identify other treatment needs earlier and expedite needed interventions. A second benefit is the personal benefit to older and homebound patients who may otherwise be feeling isolated.

Home-based care programs: As patients and providers become more comfortable with telemedicine, out-patient programs can be expanded to nontraditional program participants.

The COVID-19 pandemic has created a health care environment that necessitates limiting the need for physical contact. This requirement may very well have created some quality improvements in the provision of care.

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